

Correspondence

Case conference Strive officiously to keep alive

SIR,
May I comment briefly on the Case Conference 'Strive officiously to keep alive', Vol. 3, No. 4, pp. 189-93. I fear that the commentary on the case offered by C K Drinkwater is misleading. Drinkwater contem-

plates
'three different legal codes being applied to this situation by three different societies or by the same society at different stages in time:

1. Everything possible should be done to prolong life;
2. Given certain safeguards an individual should, in certain circumstances, have the right to choose whether or not to die;
3. The individual may be sacrificed for the sake of the group.'

Several points must be made initially.

First, codes 1) and 2) are not necessarily mutually exclusive. They can coexist; code 1) indicating a general proposition to be followed in the absence of an expressed wish by the patient, which, if made, would invoke code 2).

Second, code 1) does not necessarily mean what Drinkwater wants it to mean since it turns on a definition of 'life', which is, at bottom, a normative issue.

Third, it is not clear why code 2) should limit an individual's right to choose to 'certain circumstances', or what these circumstances are. It seems to contemplate an alternative, not mentioned, according to which the individual's right exists in *all* circumstances.

Fourth, the expression 'choose whether or not to die' in code 2) is curious at best. What I think is meant is that the patient shall have the right to refuse treatment, even though death may well follow as a consequence of such refusal.

Fifth, none of the codes makes provision for one of the central problems in the case conference; the

exercise of the patient's right to refuse treatment 'by proxy' i.e. by the daughter speaking for the patient.

When Drinkwater moves on to discuss the state of the law at present he is quite simply wrong. The law in England and Wales, and in a growing number of jurisdictions in the USA does *not* favour code 1). The attempt to justify the assertion that it does, by writing that 'a person commits homicide who directly or indirectly by any means causes the death of a human being' demonstrates a lack of appreciation of how crude an analysis of an extremely complex situation this assertion is. For instance, the words, 'directly', 'indirectly' and 'causes' all demand careful examination, and no mention at all is made of the ingredient of an *intention* to kill. It also ignores developments in legal writing and legal decisions over the past decade or so.

If anything, code 2) represents, albeit partially, the law in England and Wales. I have tried to set out the law in detail elsewhere and do not wish to repeat it here. Suffice it to say that:

1. A patient may refuse treatment and cannot be compelled to submit to it, even though the refusal may result in death occurring sooner rather than later, provided he is lucid and competent to do so.
2. A doctor is not obliged to give nor a patient to receive treatment which can be categorised as 'hopeless' or 'heroic' according to established principles. Withdrawal of or abstinence from such treatment is legally justified.
3. A doctor may not, with the primary intention of bringing about death, by any act or omission precipitate the death of a patient.

To say that decisions in such cases depend 'upon the beliefs and values of individual physicians', as 'the law ... appears reluctant to get entangled' is, I think, erroneous. There is law, though it may not appear in a statute.

The California Natural Death Act, passed in 1976, is not 'the first legal recognition of a change in the *status quo*', but, as its preamble makes quite clear, was intended to allay any doubts as to the state of the existing law.

Further, to argue that law is 'not an appropriate vehicle for dealing with such sensitive issues', because of its 'necessary rigidity' is remarkable for at least two reasons. First, law is not necessarily rigid. A code of practice, case law or even a statute can set guidelines and still leave room for the proper exercise of discretion and good faith. Second, the law is already involved whether Drinkwater likes it or not. Every act or omission of a doctor is susceptible of being analysed by reference to prevailing legal norms. If Drinkwater were to concede that the issues involved in treating the terminally ill raise fundamental normative questions and require regulation by reference to normative systems, he would agree that there can be no dispensation for doctors in this, as in any other area, nor do I think would doctors want one.

Finally, the really difficult issue of 'proxy refusal' on behalf of an unconscious or incompetent patient remains unanswered. The New Jersey Supreme Court in *Quinlan*'s case took the view that refusal of treatment by a relative on the ground that this is what the patient, if consulted would have wanted, was sufficient to absolve the doctor from any further obligation to treat the patient, where the court was satisfied that the relative was acting in good faith. There is no real guide available yet in English law, though several cases in the USA have been decided contrary to the view taken in *Quinlan*. The analogy which could be made in England with the law on parents and their children and the rule that parents may only refuse (or consent to) treatment on their children if, judged objectively, this is in the best interests of the child, may not be ideal. I see dangers in

adopting a rule of 'proxy refusal'. For example, I can easily conjure the spectre of the apparently concerned but in fact self-interested and greedy, son or daughter refusing treatment for an elderly patient with the words, 'Mommy specifically said she would rather be left to die than run the risk of being paralysed', when it is the inheritance which is really in mind. I would thus oppose acceptance of this part of *Quinlan's* case as English law.

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Author's response

SIR,

I am sorry that Mr Kennedy should find my commentary misleading. My three different codes, which were not intended to be mutually exclusive, were designed to illustrate general propositions which might help practising doctors examine some of the values which lie behind their actions. As such they are obviously open to the criticism of detail in which Mr Kennedy has indulged.

Similarly, his strictures on my interpretation of the law relating to homicide are no doubt correct. I would argue however that many doctors believe that the law favours the first position, and that this there-

fore rather than legal statute or case law will be the framework in which they make their decisions. The fact that a statute (The California Natural Death Act) is necessary 'to allay any doubts as to the state of the existing law' would seem to support this view, and the change in the *status quo* therefore becomes a change of interpretation or of emphasis.

Mr Kennedy's more detailed presentation of the law seems to provide little help when applied to the case in question.

First, 'a patient may refuse treatment - provided he is lucid and competent to do so'. This patient was not in fact lucid or competent and treatment was refused by proxy. Mr Kennedy while stating that there is no real guide available yet in English law feels that 'proxy refusal' is unacceptable because of 'the spectre of an apparently concerned, but in fact self-interested and greedy, son or daughter who only have the inheritance in mind'. My own judgement is that belief and trust in the good faith of the relatives is a better and more dignified basis for action, and that a general practitioner who may have known the individuals involved for several years is in a good position to assess their motives.

Second, 'a doctor is not obliged to give nor a patient to receive treatment which can be categorized as "hopeless" or "heroic" according

to established principles'. Mr Kennedy would no doubt assert that the definition of 'hopeless', 'heroic' and 'established principles' are all normative issues. In this case however the two medical participants, albeit from different cultures, presumably disagreed about established principles and about whether or not treatment was hopeless. So who is to decide?

Third, 'a doctor may not, with the primary intention of bringing about death, by any act or omission precipitate the death of a patient'. 'Intention' is here the crucial issue and presumably one has to ascertain whether the doctor was acting in good faith in the best interests of the patient. But in whose interests am I acting when I arrange to admit a patient with dementia to hospital, because the relatives can no longer cope, if I know that it is not uncommon for such patients to deteriorate and die when removed from a known environment.

Ultimately Mr Kennedy and I disagree about the extent to which such issues can or should be controlled. Regulation by reference to normative systems would seem to deny the uniqueness of each and every terminal illness, and the sensitivity and flexibility which is required in the management of such illnesses.

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